REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Please type or print the patient's information:

Last Name	First	MI	Date of Birth (Mo/D/Yr)	Medical Record #

Street Address	City	State	Zip Code

☐ REQUEST TO ACCESS AND INSPECT MY PROTECTED HEALTH INFORMATION ONSITE

☐ LAC+USC Medical Center	☐ Rancho Los Amigos National Rehabilitation Center
☐ Olive View-UCLA Medical Center	☐ High Desert Regional Health Center
☐ Harbor-UCLA Medical Center	☐ Martin Luther King, Jr. Outpatient Center
☐ CHC/Health Center: _____	
☐ Other: _____	

Facility Name Street Address City State Zip Code

☐ REQUEST THE FACILITY ABOVE SEND A COPY OF MY REQUESTED PROTECTED HEALTH INFORMATION TO:

Name	Phone Number (include area code)

Street Address	City	State	Zip Code

INFORMATION TO BE ACCESSED, COPIED, OR INSPECTED:

_____

_____

_____

INSPECTION PERIOD: I request information during the following time period:

FROM _____ / _____ / _____ **TO** _____ / _____ / _____
Month Day Year Month Day Year

☐ REQUEST SUMMARY OF REQUESTED PROTECTED HEALTH INFORMATION (if available)

Copy fees: DHS may charge you a reasonable fee for making copies of your protected health information at a charge of 25 cents per page for paper or fax copies; 50 cents per page for copies from microfilm.

YOUR RIGHTS REGARDING THIS REQUEST TO ACCESS:
Right to Receive a Copy of This Request – I understand that I am entitled to a signed copy of the form if I submit this form in person.

MRUN

NAME

DOB/GENDER

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION
HS1016 (3-12)

Right to Request Review of Denial of Access – I understand that DHS may deny my request to access my protected health information, in whole or in part. If I am denied access, I may request a review of their decision by submitting a *Request for Review of Denial of Access to Protected Health Information*. In most circumstances, DHS will then designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of my request.

SIGNATURE OF PATIENT: _____

OR

SIGNATURE OF PERSONAL REPRESENTATIVE: _____

If signed by other than patient, state relationship and authority to do so:

_____

DATE: _____ / _____ / _____
Month Day Year

FOR OFFICE USE ONLY

Form(s) of Identification Provided:

☐ State Driver's License _____ ☐ State Identification Card _____
☐ Birth Certificate _____ ☐ Military ID _____
☐ Other (Provide details) _____

Facility: _____
Processed by: _____ Title: _____ Date: _____
Employee Name

For more information about your health privacy rights, ask the facility staff member for a copy of our ***Notice of Privacy Practices***. You may also obtain a copy by visiting our website at http://www.dhs.co.la.ca.us/ .

MRUN

NAME

DOB/GENDER

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